

MARKHAM STOUFFVILLE HOSPITAL

381 Church Street
Markham, Ontario
L3P 7P3

GERIATRIC REFERRAL

FAX TO: (905) 472-7134

Phone number: (905) 472-7387

Date: D/M/Y

Note: Please send copies of previous consults & investigations

Name of Patient		DOB (D,M,Y)	Health Card #
Address			Phone ()
Contact person if other than patient		Relationship to patient	Phone ()
Referring Physician	Billing #	Phone ()	Fax ()

Reason for referral:

- | | |
|--|--|
| <input type="checkbox"/> Falls | <input type="checkbox"/> Behavioural disturbance |
| <input type="checkbox"/> Decline in functioning | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Dementia/memory loss | <input type="checkbox"/> Polypharmacy |
| <input type="checkbox"/> Depression/mood | <input type="checkbox"/> Caregiver stress |
| <input type="checkbox"/> Delirium | <input type="checkbox"/> Frequent ER visits/hospitalizations |
| <input type="checkbox"/> Failure to thrive/weight loss | |
| <input type="checkbox"/> Other (please describe) _____ | |

Health History:

- | | |
|---|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Cancer (type & location) _____ |
| <input type="checkbox"/> Osteoporosis/fractures (location) _____ | <input type="checkbox"/> COPD |
| <input type="checkbox"/> Diabetes <input type="checkbox"/> Oral Meds <input type="checkbox"/> Insulin <input type="checkbox"/> Diet | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> CAD <input type="checkbox"/> CHF | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Hearing loss |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Stroke |

Medications:

Allergies:

Social History:

Lives: Alone With family In retirement home Other: _____

Other Comments:



M.D.